State of New Jersey
Department of Labor and Workforce Development
DIVISION OF WORKERS' COMPENSATION

ORDER FOR TOTAL DISABILITY w/Social Security Offset

CASE NO'S.:
VICINACE:

WC	375 (03-29-06)			VICINAGE.				
	SOCIAL SECURITY NUMBER:] ~	SSN FEDERAL EMPLOYER NUMBER NJ REG NUMBER				
PETITIONER	NAME:	DOB:	NE	NAME:				
	NAME.	DOB.	III	IVANIL.				
Ě	ADDRESS (Including County):		PET	ADDRESS:				
PE			FOR					
			EY]					
	VS NAME:		APPEAI	TELEPHONE NUMBER (AREA CODE):				
Ę				APPEARING:				
RESPONDENT	ADDRESS (Including County):			NAME SELF-INSURED TPA				
PO	The state of the s		ACE R					
RES			RAZ	CLAIM NUMBER;				
	NAME:		INSURANCE CARRIER	DATE OF ACCIDENT OR				
	ADDRESS:		-	OCCUPATIONAL EXPOSURE: DESCRIBE (Briefly):				
FOR				Silvents (silviny).				
NDE								
ATTORNEY FOR RESPONDENT	TELEPHONE NUMBER (AREA CODE):							
ATT RE								
	APPEARING:							
We	ekly Wages \$			Rate(s) \$ / \$				
IF I	RE-OPENED PETITION, INDICATE FO	R LAST AWARD	· DA	TE:				
		IP: \$						
Thi	s matter having come before the COURT	on thisday	of _	:				
	ORDER FOR JUDGMENT							
It appearing that the Petitioner suffered a compensable injury on the above mentioned date while in the employ of respondent.								
The parties having settled the matter and a finding by the Court having been made that the terms of the								
	settlement are fair and just;							
	It is Ordered that this settlement be	1 1.1	, . , .	1 11 0 11 1				

PERMANENT DISABILITY:

State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION

ORDER FOR TOTAL DISABILITY w/Social Security Offset Page 2

CASE NO'S.:		
VICINAGE:		

WC-375 (03-29-06)

AWARD WITHOUT SOCIAL SECURITY OFFSETS PERMANENT: Weeks at \$ = \$ less \$ paid = Balance due \$ Voluntary Tender Reopener Credit PAYMENTS DUE FROM RESPONDENT WITH SOCIAL SECURITY OFFSETS _____ weeks at \$ _____ less \$ ____ Paid = \$ ____ + Payments before offset begins

 weeks at \$
 less \$
 Paid = \$
 +

 weeks at \$
 less \$
 Paid = \$
 +

 Payments with auxiliaries After auxiliaries weeks at \$ _____ less \$ ____ Paid = \$ ____ After offset completed TOTAL PAYMENTS **MEDICAL BILLS (Doctors and/or Institutions):** Petitioner is in receipt of Social Security Disability Benefits and the initial date of entitlement was Petitioner's 80% ACE is_____ and petitioner's initial entitlement was \$____ including \$___ for auxiliary beneficiaries. Therefore respondent is entitled to an offset resulting in a rate of \$ until petitioner's last auxiliary graduates from high school or turns 18 years of age, whichever is later. Thereafter, until the petitioner reaches 62 years of age on the offset rate shall be \$ Name of Auxiliary Date of Birth The first _____ weeks of permanent disability are to be paid at the full rate of \$____ reflecting Petitioner's share of counsel fee and costs. In the event there is a change in the number or status of the auxiliary beneficiaries while Petitioner is receiving Workers' Compensation benefits, Petitioner shall immediately notify the Respondent. I further Order that Respondent furnish the Petitioner such medical attention, prosthesis, and medical supplies as the condition of the Petitioner may require. Should any emergency arise, necessitating immediate medical attention for the Petitioner, notice and request to Respondent shall not be necessary.

Respondent authorizes ______ as treating physician.

State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION

ORDER FOR TOTAL DISABILITY w/Social Security Offset Page 3

CASE NO'S.:		
VICINAGE:		

PETITIONER (where applicable)

WC-375 (03-29-06)

The date of Petitioner's Permanent Total disability is_____ _, which is the expiration of the 450 week period, benefits to continue in accordance with the provision of N.J.S.A. 34:15-12(b) as amended. Pursuant to N.J.S.A. 34:15-12(b), petitioner will be referred to the Division of Vocational Rehabilitation Services for evaluation and services prior to the expiration of 450 weeks from the date of Total Permanent Disability. TAX IDENTIFICATION TOTAL AMT. ALLOWED PAYABLE BY PAYABLE BY NUMBER PETITIONER RESPONDENT MEDICAL FEE ALLOWED (expert and/or testimonial) ATTORNEY(S) FEE STENOGRAPHIC SERVICE MISCELLANEOUS FEES ☐ ORDER FOR CHILD SUPPORT ☐ ADDENDUM ATTACHED JUDGE OF COMPENSATION DATE WE HEREBY CONSENT TO THE ENTRY AND FORM OF THIS ORDER AND ACKNOWLEDGE RECEIPT OF COPY: PETITIONER'S ATTORNEY RESPONDENT'S ATTORNEY